CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445526	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3026 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS A Life Safety Code Survey was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities survey on 08/27/2017. During this Life Safety Survey, Lakeshore Heartland was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR Subpart 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101-2012. The requirement at 42 (CFR), Subpart 483.70(a) is NOT MET as evidenced by:	{K 000}		
{K 311} SS=D	NFPA 101 Vertical Openings - Enclosure Vertical Openings - Enclosure 2012 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least 1 hour. An atrium may be used in accordance with 8.6. 19.3.1.1 through 19.3.1.6 If all vertical openings are properly enclosed with construction providing at least a 2-hour fire resistance rating, also check this box. This STANDARD is not met as evidenced by: Based on observations, the facility failed to protect the vertical openings. The findings included: 1. Observation on 08/18/2017 at 12:19 AM, revealed the gypsum wall separating the 1st floor equipment room from the laundry room was	{K 311}		9/5/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 9/7/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

SEP 11 2017

CENTERS FOR MEDICARE & MEDICAID SERVICES

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{K 311}	Continued From page 1 moisture damaged causing the paper backing to peel and the gypsum to crumble from the wall (equipment room contains a HVAC shaft connecting all 3 floors). NFPA 19.3.1 (2012 Edition) NFPA 101, 8.6.2 (2012 Edition) 2. Observation on 08/18/2017 at 12:20 PM, revealed the following penetrations in the gypsum wall separating the 1st floor equipment room from the laundry room: a. 3 inch steel pipe b. ½ inch metal conduit NFPA 19.3.1 (2012 Edition) NFPA 101, 8.6.3 (2012 Edition) NFPA 101, 8.3.5.1 (2012 Edition) 3. Observation on 08/18/2017 at 12:47 PM, revealed the block elevator shaft wall was not sealed to the deck. NFPA 19.3.1 (2012 Edition) NFPA 101, 8.6.3 (2012 Edition) NFPA 101, 8.3.6.5 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 311}		9/7/17 9/7/17
{K 353} SS=D	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.	{K 353}		

K311- The facility maintains stairways, elevator shafts, light and ventilation shafts, chutes and other vertical openings with appropriate 1 and 2 hours fire ratings.

The gypsum wall separating the 1st floor equipment room from the laundry room was repaired by Hendrick Contracting on August 30, 2017.

The penetration in the gypsum wall relative to the three inch steel pipe and ½ inch metal conduit were repaired by Firestop Technologies on September 7, 2017.

The block elevator shaft wall was sealed to the deck on August 30, 2017.

The facility has a system overseen by the Director of Environmental Services to remedy problems of this nature through use of approved vendors and inspection of work upon completion.

The Director of Environmental Services and maintenance staff will monitor work done by outside vendors and do routine inspections for penetration as part of preventive maintenance checks according to weekly, monthly, quarterly, semi-annual and annual checks for numerous life safety issues.

Additional checks will be conducted every 2 weeks for 8 weeks by the Director of Environmental Services or designee to ensure compliance and will continue as needed until substantial compliance is achieved.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{K 311}	Continued From page 1 moisture damaged causing the paper backing to peel and the gypsum to crumble from the wall (equipment room contains a HVAC shaft connecting all 3 floors). NFPA 19.3.1 (2012 Edition) NFPA 101, 8.6.2 (2012 Edition) 2. Observation on 08/18/2017 at 12:20 PM, revealed the following penetrations in the gypsum wall separating the 1st floor equipment room from the laundry room: a. 3 inch steel pipe b. ½ inch metal conduit NFPA 19.3.1 (2012 Edition) NFPA 101, 8.6.3 (2012 Edition) NFPA 101, 8.3.5.1 (2012 Edition) 3. Observation on 08/18/2017 at 12:47 PM, revealed the block elevator shaft wall was not sealed to the deck. NFPA 19.3.1 (2012 Edition) NFPA 101, 8.6.3 (2012 Edition) NFPA 101, 8.3.6.5 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 311}		
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{K 353}	Continued From page 2 a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: This deficient practice affected 5 of 5 smoke compartments Based on document review, the facility failed to maintain the sprinkler system. The finding included: Document review on 08/18/2017 at 11:57 AM, revealed the facility failed to conduct a 5 year internal sprinkler obstruction investigation. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.1.1 (2012 Edition) NFPA 13, 24.6.1 (2010 Edition) NFPA 25, 14.2.1 (2011 Edition) NFPA 25, 14.2.1.4 (2011 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 353}		
{K 355} SS=D	NFPA 101 Portable Fire Extinguishers Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers.	{K 355}		8/29

K353- Sprinkler System – The maintenance and testing of automatic sprinkler and standpipe systems are inspected, tested, and maintained as part of ongoing maintenance schedules.

Five year internal sprinkler obstruction investigation was completed by Bouchard Fire Protection, Inc., on August 29, 2017.

The Director of Environmental Services schedules inspections as needed, and uses preventive maintenance logs as a reminder.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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{K 353}	Continued From page 2 a) Date sprinkler system last checked b) Who provided system test c) Water system supply source Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by: This deficient practice affected 5 of 5 smoke compartments Based on document review, the facility failed to maintain the sprinkler system. The finding included: Document review on 08/18/2017 at 11:57 AM, revealed the facility failed to conduct a 5 year internal sprinkler obstruction investigation. NFPA 101, 19.3.5.1 (2012 Edition) NFPA 101, 9.7.1.1 (2012 Edition) NFPA 13, 24.6.1 (2010 Edition) NFPA 25, 14.2.1 (2011 Edition) NFPA 25, 14.2.1.4 (2011 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 353}		
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{K 355}	Continued From page 3 18.3.5.12, 19.3.5.12, NFPA 10 This STANDARD is not met as evidenced by: This deficient practice affected 5 of 5 smoke compartments. Based on document review, the facility failed to maintain the portable fire extinguishers. The findings included: Document review on 08/18/2017 at 12:06 AM, revealed the facility failed to conduct the annual fire extinguisher inspection during 2017 (more than 12 months since last inspection) NFPA 101, 19.3.5.12 (2012 Edition) NFPA 101, 9.7.4.1 (2012 Edition) NFPA 10, 7.3.1.1.1 (2010 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 355}		
{K 372} SS=D	NFPA 101 Subdivision of Building Spaces - Smoke Barrie Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	{K 372}		

K355- Portable fire extinguishers are selected, installed, inspected and maintained as part of ongoing maintenance schedules.

All portable fire extinguishers were inspected by Koorsen Fire and Safety on August 29, 2017.

The Director of Environmental Services schedules annual inspections, and uses preventive maintenance logs as a reminder.

Portable fire extinguishers will be inspected monthly by the Director of Environmental Services and maintenance staff.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

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{K 372}	Continued From page 4 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain the building space subdivision. The findings included: Observation on 08/18/2017 at 12:41 PM, revealed the cross corridor wall by room 309 had two holes improperly patched (blow out patches) NFPA 19.3.7.3 (2012 Edition) NFPA 101, 8.5.6.2 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 372}		
{K 500} SS=D	NFPA 101 Building Services - Other Building Services - Other List in the REMARKS section any LSC Section 18.5 and 19.5 Building Services requirements that are not addressed by the provided K-tags, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567. This STANDARD is not met as evidenced by: This deficient practice affected 5 of 5 smoke compartments. Based on observation and document review, the facility failed to maintain the emergency power system. The findings included:	{K 500}		

K372- The facility maintains smoke barriers to a ½-hour fire resistance rating.

Two holes were properly patched on the corridor wall by room 309 by Hendrick Contracting, on August 30, 2017.

The Director of Environmental Services or designee will perform monthly checks and use preventive maintenance logs as a reminder.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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{K 500}	Continued From page 5 1. Document review on 08/18/2017 at 12:05 AM, revealed the facility failed to conduct the annual 1 ½ hour generator load bank test (last documented report 4/2016). NFPA 101, 19.5.1.1 (2012 Edition) NFPA 101, 9.1.3.1 (2012 Edition) NFPA 110, 8.4.2 (2010 Edition) NFPA 110, 8.4.2.3 (2010 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 500}		
{K 521} SS=D	NFPA 101 HVAC HVAC Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: This deficient practice affected 5 of 5 smoke compartments. Based on document review, the facility failed to maintain the HVAC systems. The findings included: Document review on 08/18/2017 at 12:08 AM, revealed the facility failed to conduct a 4 year fire damper inspection. NFPA 101, 19.5.2.1 (2012 Edition) NFPA 101, 9.2.1 (2012 Edition) NFPA	{K 521}		9/7

K500- Facility will conduct an annual 1 ½ hour generator load bank test.

Annual 1 ½ hour generator load bank test was completed by Nixon Power Services Company on April 4, 2017.

The Director of Environmental Services schedules inspections as needed, and uses preventive maintenance logs as a reminder.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.

compliance: 9/07/17

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{K 521}	Continued From page 6 90A, 5.4.7.1 (2012 Edition) NFPA 80, 19.4 (2010 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 521}		
{K 920} SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: This deficient practice affected patient rooms in 4 of 4 smoke compartments on the 3rd and 4th floors (2 on each floor) of the facility.	{K 920}		8/21

K521- Facility installs and maintains heating, ventilation, and air conditioning in accordance with the manufacturers specifications.

Four year fire damper inspection was completed by Lee Company on September 7, 2017.

The Director of Environmental Services schedules inspections as needed, and uses preventive maintenance logs as a reminder.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445526	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 521}	Continued From page 6 90A, 5.4.7.1 (2012 Edition) NFPA 80, 19.4 (2010 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{K 521}		
{K 920} SS=D	NFPA 101 Electrical Equipment - Power Cords and Extens Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This STANDARD is not met as evidenced by: This deficient practice affected patient rooms in 4 of 4 smoke compartments on the 3rd and 4th floors (2 on each floor) of the facility.	{K 920}		8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445526	A. BUILDING 01 - MAIN BUILDING 01 B. WING	R 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 920}	Continued From page 7 Based on observations, the facility failed to comply with CMS regulation requirements for power strips used in patient care area. The findings included: Observation on 08/18/17 at 11:11 AM- 11:32 AM, revealed power strips not approved for use in patient care areas throughout (3rd and 4th floors) but not limited to the following locations: a. 309 b. 318 c. 411 (power strips plugged in back to back). CMS letter Ref: S&C: 14-46-LSC; NFPA 99, 12.2.4.2.1 (2012 Edition) The administrator was present when these deficiencies were identified and were later acknowledged in the exit conference on 08/18/17. CMS S&C 14-46	{K 920}		

K920- Power strips in a patient care vicinity are only used for components of movable patient care related electrical equipment assembles that have been assembled by qualified personnel and meet proper conditions.

Facility's maintenance assistant and the administrator completed a facility wide audit and replaced all power strips.

The Director of Environmental Services or designee will perform random room inspections as needed, and uses preventive maintenance logs as a reminder.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.

Compliance: 8/21/17 c.H.

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1914	A. BUILDING: 01 - MAIN BUILDING 01 B. WING	R 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(N 831)	1200-8-6-.08 (1) Building Standards (1) A nursing home shall construct, arrange, and maintain the condition of the physical plant and the overall nursing home environment in such a manner that the safety and well-being of the residents are assured. This Rule is not met as evidenced by: Based on observation and document review, the facility failed to maintain the physical plant and overall environment. The findings included: 1. Document review on 08/18/2017 at 12:41 AM, revealed the facility failed to conduct the annual fire door inspection during 2016. NFPA 101, 4.4.2.1 (2012 Edition) NFPA 101, 8.2.2.4 (2012 Edition) NFPA 80, 5.2.1 (2010 Edition) 2. Observation on 08/18/2017 at 12:41 PM, revealed the 2 holes improperly patched in the corridor wall at the 3rd floor elevator. NFPA 101, 8.3.5.1 (2012 Edition) 3. Observation on 08/18/2017 at 12:41 PM, revealed a penetration by a low voltage wire not sealed properly in the corridor wall at the 3rd floor elevator. NFPA 101, 8.3.5.1 (2012 Edition) 4. Observation on 08/18/2017 at 12:41 PM, revealed a penetration by a low voltage wire not sealed properly above the door to room 309. NFPA 101, 8.3.5.1 (2012 Edition) 5. Observation on 08/18/2017 at 12:41 PM, revealed a penetration by a sprinkler pipe not	(N 831)		9/7 9/7 9/7 9/7

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Administrator 9/7/17

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1914	A. BUILDING: 01 - MAIN BUILDING 01 B. WING	R 08/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKESHORE HEARTLAND	3025 FERNBROOK LANE NASHVILLE, TN 37214

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{N 831}	Continued From page 1 sealed properly in the corridor wall above room 303. NFPA 101, 8.3.5.1 (2012 Edition) 6. Observation on 08/18/2017 at 12:41 PM, revealed 2 penetrations by insulated water pipes not sealed properly in the corridor wall above the door to 3rd floor shower room. NFPA 101, 8.3.5.1 (2012 Edition) 7. Observation on 08/18/2017 at 12:41 PM, revealed the corridor wall was not sealed to the deck at the 3rd floor shower room. NFPA 101, 8.3.6.2 (2012 Edition) 8. Observation on 06/27/2017 at 12:49 PM, revealed a penetration by a low voltage wire not sealed properly above the door to room 319. NFPA 101, 8.3.5.1 (2012 Edition) 9. Observation on 06/27/2017 at 12:56 PM, revealed the 2 holes improperly patched in the corridor wall at the 4th floor elevator. NFPA 101, 8.3.5.1 (2012 Edition) 10. Observation on 06/27/2017 at 12:56 PM, revealed a penetration by a low voltage wire not sealed properly above the door to room 404. NFPA 101, 8.3.5.1 (2012 Edition) 11. Observation on 08/18/2017 at 12:41 PM, revealed a penetrations by a metal-clad cable not sealed properly in the corridor wall above the door to 4th floor shower room. NFPA 101, 8.3.5.1 (2012 Edition) Maintenance staff was present when the deficiencies were identified and the administrator acknowledged the deficiencies during the exit conference on 08/18/2017.	{N 831}		9/7 9/7 9/7 9/7 9/7 9/7

N831- Physical plant environment shall be properly constructed and well maintained to ensure staff and resident safety.

Annual Fire Door Inspection was completed by Premier Firestop on September 1, 2017.

All penetrations were properly sealed by Firestop Technologies on September 7, 2017.

The Director of Environmental Services schedules inspections as needed, and uses preventive maintenance logs as a reminder.

The Administrator and Director of Environmental Services will monitor results of these checks and report to the facility's Quality Assurance Committee. The monitor and in-service training will continue as determined by the Administrator or as directed by the Quality Assurance Committee which consists of the administrator, DON, medical director, social worker, health information manager, maintenance supervisor, activity director, and Administrative Nurses.